

Deputy Sheriff New Hire Guide



Welcome to King County!

King County deputy sheriffs enjoy a comprehensive package of health and insurance benefits. This guide explains those benefits and includes the forms you need to get you and your family enrolled. Please review the information and return your enrollment forms ***within a week after you begin work*** to:

Sheriff's Office Personnel Unit
King County Courthouse KCC-SO-0100
516 Third Avenue
Seattle WA 98104-2312

This guide is not a complete description of each plan. More details about each benefit are in plan booklets available at www.metrokc.gov/finance/benefits or by request from Benefits and Retirement Operations. Although we've made every effort to ensure this guide is accurate, provisions of the official plan documents and contracts govern in the case of any discrepancy. The benefit program is subject to review and may be modified or terminated at any time for any reason. This guide does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

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Eight Key Points

- 1.** King County pays for medical/vision, dental and basic life insurance for you and the eligible family members you enroll, plus basic accidental death and dismemberment (AD&D) insurance for you. You may purchase additional enhanced life insurance for yourself.
- 2.** You need to return your enrollment forms within a week after you begin work to:
 - Elect a medical/vision plan
 - Elect or decline enhanced life insurance for yourself
 - Designate your insurance beneficiaries
 - Enroll your benefit eligible family members for coverage.
- 3.** Coverage begins the first of the month following your hire date, as determined by your department. If your hire date is the first of the month, your coverage begins the same day.
- 4.** It takes several weeks to process your enrollment and issue your medical/vision card (no cards are issued for dental). If you don't receive your medical/vision card within 30 days, contact your medical/vision plan. If you have difficulty getting services, contact Benefits and Retirement Operations.
- 5.** Open enrollment every October lets you change coverage effective the following January. However, if you first enroll for benefits in October, November or December you are not eligible for that year's open enrollment and the coverage you elect remains in effect through the following year. During open enrollment you may:
 - Change medical/vision plans
 - Add enhanced life for yourself with evidence of insurability
 - Add eligible family members not previously covered.
- 6.** You may make certain changes to your benefit coverage between open enrollments. Generally, you must notify Benefits and retirement Operations within 30 days of the event prompting the change. Change forms are available at www.metrokc.gov/finance/benefits and give specific deadlines. Between open enrollments you may:
 - Drop family members from coverage with appropriate documentation
 - Drop enhanced life for yourself
 - Add eligible family members for coverage if you have a qualifying event. For example:
 - Birth or placement for adoption of a child
 - Placement of a foster child
 - Marriage or establishment of a domestic partnership
 - Qualified Medical Child Support Order
 - Significant change in your spouse/domestic partner's coverage through his/her employment
 - Request continuation of coverage for a child currently enrolled in county benefits past age 23 if the child is chiefly dependent on you for support and maintenance and becomes incapacitated due to a developmental or physical disability before turning 23.
- 7.** To keep costs down, all plan information is posted at www.metrokc.gov/finance/benefits, but hard copies are available by request from the Sheriff's Office Personnel Unit.
- 8.** If you have questions about getting enrolled for benefit coverage, contact the Sheriff's Office Personnel Unit. Otherwise, call 206-684-1556, e-mail kc.benefits@metrokc.gov or visit www.metrokc.gov/finance/benefits!

Benefits That Need Your Decisions

You must submit your enrollment forms within a week after you begin work to:

- Choose your medical/vision plan
- Elect or decline enhanced life insurance for yourself
- Designate your insurance beneficiaries
- Enroll your benefit eligible family members for coverage.

These "decision" benefits are summarized in this section. For more details, including exclusions, limitations or preauthorization requirements, refer to the plan booklets available at www.metrokc.gov/finance/benefits, contact the Sheriff's Office Personnel Unit or contact the other resources listed in the Resource Directory.

► What medical/vision plan is best for you?

King County pays for medical/vision coverage for you and the family members you enroll. You may choose from three plan options. The option you select is the option your family members receive.

Plan Feature	Regence BlueShield	PacifiCare	Group Health
Annual deductible	\$100 per person/\$300 per family	None	None
Copay/office visit	None	\$5	\$7
After deductible/copays, plan pays most covered expenses at ...	80% - 100%	100%	100%
Until you reach your annual out-of-pocket expenses of ... then most expenses are paid at 100% for rest of year	\$375/person (excluding deductible)	\$500 per person/\$1,500 per family	\$1,000 per person/\$2,000 per family
Lifetime maximum	\$1,000,000	No limit	No limit
Requires primary care physician (PCP)	No	Yes	Yes
Additional benefits for LEOFF 1 employees with occupational injuries	None	None	100% ambulance services No emergency room care copay 100% skilled nursing facility care up to 30 days/condition
Alternative care	100%	100% after \$5 copay/visit	100% after \$7 copay/visit Referral required; limits apply; call plan for details
Ambulance services	80%	100%	80% for ground or air transport (100% for LEOFF 1 with occupational injuries) 100% for ground transfers when initiated by Group Health
Chemical dependency treatment	100% inpatient 100% outpatient \$12,000 maximum/24 months	100% inpatient 100% outpatient \$12,000 maximum/24 months	100% inpatient 100% outpatient after \$7 copay/visit \$11,285 (2003)/\$11,841 (2004) maximum/24 months

Plan Feature	Regence BlueShield	PacifiCare	Group Health
Chiropractic care	100%	100% after \$5 copay when referred by PCP 100% after \$10 copay/visit up to 33 visits/year when self-referred (must see a network provider)	100% after \$7 copay/visit when medically necessary
Circumcision	100%	100%	100%
Diabetes care training	100%	100%	100% after \$7 copay/visit
Durable medical equipment and diabetic equipment	80%	100%	80%
Emergency care (in an emergency room)	80% after \$25 copay (waived for accidental injury, surgery or if directly admitted)	100% after \$50 copay/visit (waived if admitted)	100% after \$75 copay/visit at network facility (waived if admitted) \$125 copay/visit at non-network facility (waived if LEOFF 1 with occupational injuries)
Family planning	Covered at various levels; call plan for details	100%	Covered at various levels; call plan for details
Home health	90% up to 130 visits/year	100% up to 130 visits/year	100%
Hospice care	90% (the greater of 6 months or \$10,000 lifetime maximum)	100% (6-month lifetime maximum)	100% (limits apply; call plan for details)
Hospital care	80% inpatient and outpatient	100%	100%
Lab, x-rays and other diagnostic testing	100% physician services 80% hospital services	100% (includes mammograms, prenatal tests)	100%
Manipulative therapy (including chiropractic services)	See chiropractic care	See chiropractic care	100% after \$7 copay/visit
Maternity care - delivery and related hospital care	100% physician services 80% hospital services	100% after \$10 copay/pregnancy	100%
Maternity care - prenatal and postpartum care	100% physician services 80% hospital services	100% after \$10 copay/pregnancy	100% after \$7 copay/visit
Mental health care - inpatient	100% up to 8 days/year	100% up to 30 days/year; 100% residential and day treatment (also subject to inpatient maximum; each day of care counts as half an inpatient day)	80% up to 12 days/year
Mental health care - outpatient	50% up to 12 visits/year	100% after \$5 copay/visit up to 30 visits/year	100% after \$20 copay/individual, family or couple/visit and \$10 copay/group session up to 20 visits/year
Neurodevelopmental therapy - inpatient (for children age 6 and under)	80% up to \$2,000 annual benefit maximum	100%	100% up to 60 days/condition/year
Neurodevelopmental therapy – outpatient (for children age 6 and under)	80% up to \$2,000 annual benefit maximum	100% after \$10 copay/visit up to 60 visits/condition	100% after \$7 copay/visit up to 60 visits/condition/year

Plan Feature	Regence BlueShield	PacifiCare	Group Health
Newborn care (up to at least 3 weeks as mandated by state law)	100% physician services 80% hospital services	Covered at various levels; call plan for details	Covered at various levels; call plan for details
Physician and other medical and surgical services (includes benefits for mastectomy-related services - reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy, including lymphedema; call plans for more information)	100% physician services in an office, home, hospital or skilled nursing facility 100% physician services for surgery 100% lab and x-ray	100% inpatient 100% outpatient after \$5 copay/visit	100% inpatient 100% outpatient after \$7 copay/visit
PKU formula	100%	100%	100%
Prescription drugs - up to 30-day supply through network pharmacies	100% after \$7 copay for generic 100% after \$12 copay for preferred brand 100% after \$27 for non preferred brand Copays do not apply against deductible	100% after \$5 copay/prescription or refill	100% after \$5 copay/prescription or refill
Prescription drugs - up to 90-day supply through mail order	100% after \$14 copay for generic 100% after \$24 copay for preferred brand 100% after \$54 copay for non-preferred brand Copays do not apply against deductible	100% after \$10 copay/90-day supply	100% after \$5 copay/30-day supply
Preventive care (such as routine exams and immunizations)	100%	100% after \$5 copay/visit	100% after \$7 copay/visit
Radiation therapy, chemotherapy and respiratory therapy	100% for radiation and chemotherapy; for respiratory therapy see home health, hospice or hospital care sections	100%	100% after \$7 copay/visit
Rehabilitative services – inpatient	100% up to \$50,000/condition	100%	100% up to 60 days/condition/year
Rehabilitative services – outpatient	80% up to \$2,000/year	100% after \$10 copay/visit up to 60 days or visits/condition/year	100% after \$7 copay up to 60 visits/condition
Skilled nursing facility	80% to 90 days/year	100% up to 150 days lifetime maximum/condition (must be in place of a hospital stay)	100% up to 60 days/condition For LEOFF 1 with occupational injuries up to 30 days/condition
Smoking cessation - sessions	75% after deductible/network provider \$500 lifetime maximum	100% after \$20 copay/network program	100% network provider 1 program/year maximum

Plan Feature	Regence BlueShield	PacifiCare	Group Health
Smoking cessation - nicotine replacement	Not covered	100% after \$20 copay for each 4-week supply if prescribed by PCP (90-day treatment maximum)	100% or \$5 copay/30-day supply (whichever is less) for network program
Sterilization procedures	100%	100%	100% after \$7 copay/visit
Supplemental accident benefits	100% up to \$600/injury Deductible does not apply	Not covered	Not covered
TMJ	Not covered	Not covered	Up to \$1,000 maximum/person/year in plan payments Lifetime maximum of \$5,000/person
Tooth injury	100% physician/dentist/denturist services 80% hospital services (up to \$600/injury) Deductible does not apply	100%	Not covered
Transplants (certain transplants/services only)	100% physician and travel expenses 80% hospital services; (donor organ procurement costs up to \$50,000; travel expenses up to \$2,500/transplant)	100% up to \$500,000 lifetime maximum	100%
Urgent care	Covered at various levels; call plan for details	100% after \$5 copay/visit	100% after \$7 copay/visit
Vision care - eye exams	100% for 1 exam/calendar year Deductible does not apply	100% for 1 exam every 12 months	100% after \$7 copay for 1 exam every 12 consecutive months (must use Group Health providers)
Vision care - eyeglasses (frames and lenses)	Allowance/lens (maximum of 2 separate lenses/calendar year): Single vision \$20 Bifocal \$30 Trifocal \$40 Lenticular or aphakic \$65 Frames (every 2 years) \$30	100% for 1 pair of glasses and frames/person/24 months (Cole Vision Service providers) 100% to maximum allowable benefit of \$100 (non-participating providers)	Not covered
Vision care - contact lenses (instead of glasses)	Medically necessary, up to \$100/lens provided only for aphakia or if vision is correctable to 20/70 or better only by use of contact lenses If cosmetic, single lens allowance applies Deductible does not apply	100% up to \$100 for standard contacts (benefits limited to once every 24 months)	Not covered

► Do you want enhanced life insurance for yourself?

You automatically receive county-paid basic life insurance (page 11), but may purchase enhanced life insurance for yourself in the amount of your base annual salary less \$6,000. If you elect this enhanced coverage, you pay the full cost: \$.334/\$1,000 each month (the rate is the same in 2003 and 2004). If you die, your beneficiaries receive the amount you elect in addition to your county-paid basic life insurance.

An example to help you figure the cost: If your base annual salary is \$45,000 and you elect enhanced coverage, your enhanced coverage amount is \$45,000 - \$6,000 = \$39,000. In 2003, you pay \$.334 x 39 = \$13.03 each month for this amount.

No evidence of insurability is required if you elect enhanced life when you're first eligible, but evidence of insurability is required if you elect it during a subsequent open enrollment. However, you may add enhanced life insurance between open enrollments (without evidence of insurability) for certain qualifying changes in status. You may add it when you marry or establish a new domestic partnership, and when you cover your first child under your other health plans. To add coverage, you must submit an Enhanced Life/AD&D Change Form to Benefits and Retirement Operations within 30 days of the qualifying event. (You may drop or reduce coverage anytime.)

Life insurance is provided through Aetna and is portable. When you end employment with the county for reasons other than disability, you may continue to pay Aetna directly for the basic and enhanced coverage you had on your last day of employment until you reach age 75 (changes to 99 in 2004). The age-specific rates you pay for the continued coverage may be different from the rates paid by active employees.

► Who are your life and AD&D insurance beneficiaries?

Whether you elect enhanced coverage or not, you receive county-paid basic life and accidental death and dismemberment insurance. Therefore, you need to designate beneficiaries – the people you want to receive these benefits in the event of your death. To do so, complete the Beneficiary Designation Form (page 16).

Complete one form to designate the same beneficiaries for any and all life and AD&D benefits to which you're entitled. Copy and complete separate forms to designate different beneficiaries for each benefit.

The form allows you to designate primary and contingent beneficiaries. If your primary beneficiaries are not alive at the time of your death, contingent beneficiaries receive your benefit. If you name multiple beneficiaries (primary or contingent), assign the share each beneficiary receives. Shares for all primary beneficiaries need to total 100% and shares for all contingent beneficiaries need to total 100%.

For example, you might name your spouse as primary (if you're married and you do not list your spouse as your only primary beneficiary, your spouse must sign the spouse waiver section of the form) and your two children as contingents. You'd assign your spouse 100% of your insurance benefit and could assign each child 50% of the benefit, or one child 60% and the other 40% – whatever combination of shares totaling 100%. If your spouse is not alive to receive the benefit in the event of your death, your contingent children receive it.

Return original Beneficiary Designation Forms to the Sheriff's Office Personnel Unit and keep copies for your records. (The Sheriff's Office Personnel Unit forwards all forms to Benefits and Retirement Operations. If you need to update beneficiaries at a later date, contact Benefits and Retirement Operations.)

► Who are the eligible family members you want to cover?

List the family members you want to cover under your benefit plans on the Family Member Enrollment Form (page 17). Parents and other relatives who are not members of your immediate family are not eligible for coverage, but the following family members are (if you enroll them):

- Your spouse/domestic partner (attach a copy of your marriage certificate or complete and return the Affidavit of Marriage/Domestic Partnership, page 18)

- Unmarried children of you or your spouse/domestic partner if they are under age 23 and chiefly dependent on you for support and maintenance (generally, that means you may claim them on your federal tax return); they may be your:
 - Natural children
 - Adopted children (or children legally placed with you for adoption or for whom you assume total or partial legal obligation for support in anticipation of adoption)
 - Stepchildren
 - Legally designated wards (legally placed foster children, children placed with you as legal guardian or children named in a Qualified Medical Child Support Order; attach appropriate documentation).

If you do not add eligible family members now, you must wait until the next open enrollment to add them except for certain qualifying events such as:

- Birth or placement for adoption of a child
- Placement of a legal ward
- Marriage/establishment of a domestic partnership
- Qualified Medical Child Support Order
- Significant change in your spouse/domestic partner's employer-sponsored coverage.

Generally, when a qualifying event occurs, you must submit Add New Family Member and Enhanced Life/AD&D Change forms to Benefits and Retirement Operations within 30 days of the event.

► Tax implications for domestic partner health coverage

There is no cost to cover family members, but when you cover a domestic partner (DP) and his/her children for health benefits (medical, dental, vision) the IRS taxes you on the value of the coverage. This value is added to the salary shown on your paycheck (and W-2 at the end of the year), federal income and Social Security (FICA) taxes are withheld on the higher salary amount, then the value is subtracted from your salary.

If you want to add a domestic partner and his/her child(ren) for only the county-paid basic life insurance (and not health benefits), check the “Add this family member for life insurance only (no health coverage)” box on your Family Member Enrollment Form.

Taxable values for the different combinations of health plans are shown in the following table.

Monthly Taxable Value of Health Plans	DP Only		DP's Children		DP + DP's Children	
	2003	2004	2003	2004	2003	2004
Regence BlueShield + Dental	\$ 326.61	\$ 446.18	\$ 281.03	\$ 383.97	\$ 607.64	\$ 830.15
PacifiCare + Dental	\$ 316.89	\$ 379.14	\$ 257.54	\$ 307.24	\$ 574.43	\$ 686.38
Group Health + Dental	\$ 329.79	\$ 379.96	\$ 296.95	\$ 342.31	\$ 626.74	\$ 722.27
Dental + Vision Only (Opted Out of Medical)	\$ 67.02	\$ 68.66	\$ 53.61	\$ 54.93	\$ 120.63	\$ 123.59

Do you want to participate in a Flexible Spending Account?

Flexible Spending Accounts (FSAs) allow you to set aside pretax dollars from your paycheck to pay for expenses not covered through your other benefits. When you put money into an FSA you do not pay federal or Social Security (FICA) taxes on it. As a result, your taxable income is reduced and your taxes are lower.

- Health Care FSAs allow you to set aside pretax dollars to pay for certain expenses not covered by your medical, dental and vision plans (for example, copays for office visits and the cost of orthodontia not fully paid by your dental plan).
- Dependent Care FSAs allow you to set aside pretax dollars to pay for eligible dependent care expenses for your child, disabled spouse or dependent parent while you and your spouse work.

Because of the tax advantages available to you, the IRS limits how you can use FSAs and how much you can contribute:

- Under the county plan, the maximum that can be contributed to King County's Health Care FSA is \$6,000 per year. The maximum that can be contributed to a Dependent Care FSA is \$5,000 per year if married filing a joint return or head of household; \$2,500 if married filing separately. The minimum that can be contributed to either FSA is \$300 per year.
- Health Care and Dependent Care FSAs are separate. The money you allocate for one cannot be used for the other and you cannot transfer dollars between accounts.
- Expenses for certain eligible services incurred during the calendar year are reimbursed from an FSA. You have until March 31 of the following year to file reimbursement requests.
- You must use FSA money or you lose it. Any money left in an FSA that cannot be reimbursed is forfeited, so it's important to estimate annual expenses carefully before enrolling and set aside only as much as you expect to spend.
- You cannot use a Health Care FSA to pay expenses you claim as health care deductions on your income tax return.
- Each dollar of dependent care expenses reimbursed through a Dependent Care FSA reduces the amount you can apply toward the federal Dependent Care Tax Credit.
- FSA contributions may affect Social Security benefits. Because you and the county don't pay Social Security (FICA) taxes on the money you contribute, your future Social Security benefits may be reduced slightly.

Please contact Benefits and Retirement Operations for additional details. If you decide to participate in the FSA program, submit the FSA Enrollment Form include with this guide ***within 30 days of when your other benefits begin***. Otherwise, you must wait for a qualifying event or the next open enrollment.

Benefits that need no decisions

You and the eligible family members you list on your Family Member Enrollment Form automatically receive dental and basic life insurance coverage; you receive basic accidental death and dismemberment insurance. These “automatic” benefits need no decisions so they’re not listed on your enrollment forms.

► You automatically receive dental coverage

Dental coverage is provided by Washington Dental Service. You can use any dentist you wish (most dentists in Washington participate in the WDS plan), but the benefits are generally higher (your out-of-pocket expenses are less) and the dentist automatically files your claim if you see a WDS dentist.

WDS increases your payment levels through an incentive program as long as you see your dentist each year. For diagnostic and preventive services as well as basic and restorative services, the payment level starts at 70% and increases 10% in January of each year until you reach 100% (if you do not see the dentist during the calendar year your payment level is reduced to the next lower payment level, but never below 70%)

Washington Dental Service	
Annual deductible	None, but you and each covered family member pay coinsurance (if any), amounts in excess of usual and customary rates (unless you see a participating dentist) and expenses for services not covered.
Annual maximum benefit (doesn't apply to orthodontic or TMJ services)	\$2,500/person
Covered Expenses	Plan Pays
Diagnostic and preventive services (1 exam and cleaning every 6 months, complete x-rays every 3 years, supplemental bitewing x-rays every 6 months)	70% - 100% based on your incentive level; see dental booklet for details
Basic services (fillings, stainless steel crowns, extractions, root canals, periodontics)	70% - 100% based on your incentive level; see dental booklet for details
Major services – restorative (crowns, onlays, fixed bridges)	70% - 100% based on your incentive level; see dental booklet for details
Major services – prosthodontics (dentures)	70%
Orthodontic services - adults and children	60%, up to a \$2,500 lifetime benefit maximum
Orthognathic surgery	70% up to a \$5,000 lifetime benefit maximum
Accidental injury	100%

► You automatically receive basic life insurance

You automatically receive county-paid basic life insurance. If you die for any reason the beneficiaries you designate receive \$6,000.

► You automatically receive basic life insurance for your family

The eligible family members you enroll automatically receive county-paid basic life insurance. If your spouse/ domestic partner or child (14 days or older) dies, you receive \$1,000.

If you end employment with the county for reasons other than disability and continue your coverage under the new portability option, you may continue to pay Aetna directly for the basic coverage your family members had on your last day of employment. You may pay for a spouse or domestic partner until he/she is 65 and a child until

he/she is 19 (23 if solely dependent on you for support). The age-specific rates you pay for the continued coverage may be different from the rates paid by active employees.

► **You automatically receive basic AD&D insurance**

You automatically receive county-paid basic accidental death and dismemberment insurance. If you die in a covered accident the beneficiaries you designate receive \$6,000 in addition to your basic life insurance benefit. If you are dismembered or paralyzed you receive an amount that depends on the type of loss.

Accidental death and dismemberment insurance is not available to family members.

Resource Directory

If no TTY phone number is listed, please call 711 to access TTY Relay Service.

For Questions About ...	Contact ...
Benefit – Eligibility and Enrollment	Sheriff's Office Personnel Unit KC Courthouse KCC-SO-0100, 516 Third Ave., Seattle WA 98104-2312 Phone 206-205-7601 Fax 206-684-1925
Benefits -- General <ul style="list-style-type: none"> • Open enrollment and making changes • Flexible spending account enrollment • Life and accidental death and dismemberment insurance plan details • Alternate formats 	Benefits and Retirement Operations Exchange Building EXC-ES-0300, 821 Second Ave., Seattle 98104-1598 Phone 206-684-1556 ▪ 1-800-325-6165 x41556 (outside local calling area) Fax 206-684-1925 Email kc.benefits@metrokc.gov Web www.metrokc.gov/finance/benefits
Dental <ul style="list-style-type: none"> • Providers • Claims and appeals • Other plan details 	Washington Dental Service PO Box 75983, Seattle WA 98125-0688 Phone 206-522-2300 ▪ 1-800-554-1907 E-mail cservice@deltadentalwa.com Web www.DeltaDentalWA.com
Flexible Spending Accounts <ul style="list-style-type: none"> • Account balances • Reimbursement • Other plan details 	Associated Administrators Inc. PO Box 3199, Portland OR 97208-3199 Phone 1-800-334-4340 ▪ 1-800-428-4833 TDD Fax 1-800-979-8987 E-mail flex@aai-tpa.com Web www.aai-pca.com
Life Insurance <ul style="list-style-type: none"> • Conversion or portability option when you leave employment • Evidence of Insurability (EOI) • For claims, contact Benefits and Retirement Operations 	Aetna Phone 1-800-826-7448 (conversion/portability) ▪ 1-800-523-5065 (EOI)
Medical/Vision -- General <ul style="list-style-type: none"> • Providers (doctors, hospitals, etc.) • Claims and appeals • Identification cards • Drug formulary (covered drugs, including generic, preferred brand and non-preferred brand) • Preauthorization • Other plan details (covered expenses, limitations, exclusions) 	Regence BlueShield PO Box 30271, Salt Lake City UT 84130 Phone 1-800-544-4246 Web www.regence.com (e-mail through Web site) PacifiCare PO Box 6092, Cypress CA 90630-0092 Phone 1-800-932-3004 ▪ 711 TTY Relay Service Web www.pacificare.com (e-mail through Web site) Group Health Cooperative PO Box 34585, Seattle WA 98124-1585 Phone 206-901-4636 ▪ 1-888-901-4636 ▪ 711 TTY Relay Service E-mail info@ghc.org Web www.ghc.org

For Questions About ...	Contact ...
Medical -- Prescription Mail Order Service <ul style="list-style-type: none"> • Mail order prescriptions • Claims and appeals 	Regence BlueShield members use Postal Prescription Services PO Box 42200, Portland OR 9742-0200 Phone 1-800-552-6694 ■ 711 TTY Relay Service E-mail usmyrrx1@ibmmail.com Web www.ppsrx.com PacifiCare members use Prescription Solutions PO Box 509075, San Diego CA 92150-9075 Phone 1-800-562-6223 ■ 711 TTY Relay Service Web www.rxsolutions.com (e-mail through Web) Group Health members use Group Health

Deputy Sheriff Enrollment Form



Check one box for each benefit listed. Benefits that need no decisions – dental, basic life/AD&D for you and basic life for your family – are not listed. Return **within a week after you begin work** to Sheriff's Office Personnel Unit, KC Courthouse KCC SO-0100, 516 Third Ave., Seattle 98104-2312.

► Employee Information

Last name _____ First _____ MI _____ Gender ☐ M ☐ F
 Soc Sec No _____ Birth date _____ Home phone (_____) _____
 Mailing address _____ Apt No _____ City _____
 State _____ ZIP _____ Work start date _____
 Home e-mail _____ Work phone (_____) _____

► Medical/Vision

See page 4.

- ☐ (K) RegenceBlueShield
☐ (L) PacifiCare
☐ (M) Group Health

► Enhanced Life for You

See page 8.

- ☐ Decline
☐ (1) Accept 1 x base annual salary (minus \$6,000)

► Authorization

This form supersedes all previously submitted forms. I've read and understand it and the additional materials describing my benefits. The information I've provided is true, correct and complete. I understand the willful falsification of any information I have provided may lead to disciplinary action up to and including discharge from employment. I authorize the insurance carriers to coordinate benefits and process claims for my family and me. I authorize King County to deduct the cost of any self-paid coverage I've chosen from my paycheck. I understand the elections I've made are binding and cannot be revoked or modified except as explained in the materials provided and until I submit the appropriate change form.

Employee Signature _____ Date Signed _____

Office Use Only	Received	Reviewed	Data Entered	Audited	Effective

Beneficiary Designation Form



Use this form to designate your life and AD&D insurance beneficiaries, as described on page 8. Provide all information indicated. Return original(s) to the Sheriff's Office Personnel Unit, KC Courthouse KCC SO-0100, 516 Third Ave., Seattle 98104-2312 and keep copies for your records.

► **Check One** If you check an "only" box, you must submit separate forms for each benefit for which you're eligible.

The beneficiaries I've listed receive:

- ☐ Any and all county life and AD&D insurance benefits for which I am eligible
- ☐ Only my county life insurance benefit
- ☐ Only my county AD&D insurance benefit

► Beneficiaries

	Name	Relationship	Soc Sec No	Birth Date	Contact Phone	Primary	Contingent	%
1.						<input type="checkbox"/>	<input type="checkbox"/>	
2.						<input type="checkbox"/>	<input type="checkbox"/>	
3.						<input type="checkbox"/>	<input type="checkbox"/>	
4.						<input type="checkbox"/>	<input type="checkbox"/>	
5.						<input type="checkbox"/>	<input type="checkbox"/>	
6.						<input type="checkbox"/>	<input type="checkbox"/>	
7.						<input type="checkbox"/>	<input type="checkbox"/>	
8.						<input type="checkbox"/>	<input type="checkbox"/>	
9.						<input type="checkbox"/>	<input type="checkbox"/>	
10.						<input type="checkbox"/>	<input type="checkbox"/>	
11.						<input type="checkbox"/>	<input type="checkbox"/>	
12.						<input type="checkbox"/>	<input type="checkbox"/>	
13.						<input type="checkbox"/>	<input type="checkbox"/>	

► **Spouse Waiver** Your spouse must sign if you designate anyone other than or in addition to him/her as primary above.

I am the spouse of the employee who signed this form. As such, I understand that upon the death of my spouse, I may be entitled to receive a plan benefit. I understand that by signing this statement, I hereby consent to the designation of primary beneficiary(ies) other than/in addition to myself and thereby waive my right to full payment upon the death of my spouse.

Spouse signature _____

Date signed _____

Printed name _____

► Authorization

By signing and dating this form, I designate the above as my beneficiary(ies). I understand that if a minor (person not of legal age) or my estate is the beneficiary, it may be necessary to have a guardian or legal representative appointed before any death benefit can be paid. This may mean legal expenses for beneficiary(ies) and possible delay in payment to them.

Employee signature _____

Date signed _____

Soc Sec No _____

Family Member Enrollment Form



List eligible family members for coverage and provide all information for each family member. Please print. Copy and attach additional forms if needed. If you're covering a spouse/domestic partner, complete the Affidavit of Marriage/Domestic Partnership (page 18). If you want a domestic partner (DP) or DP's children covered only for county-paid basic life and no health coverage (the value of DP health coverage is taxed, see page 9), check the "Add this family member for life insurance only" box. Otherwise, leave the box unchecked.

☐ Check this box if your spouse/domestic partner is also a King County employee.

1. Name _____ Relationship _____
Soc Sec No _____ Gender ☐ M ☐ F Birth Date _____
☐ Add this family member for life insurance only (no health coverage)
2. Name _____ Relationship _____
Soc Sec No _____ Gender ☐ M ☐ F Birth Date _____
☐ Add this family member for life insurance only (no health coverage)
3. Name _____ Relationship _____
Soc Sec No _____ Gender ☐ M ☐ F Birth Date _____
☐ Add this family member for life insurance only (no health coverage)
4. Name _____ Relationship _____
Soc Sec No _____ Gender ☐ M ☐ F Birth Date _____
☐ Add this family member for life insurance only (no health coverage)
5. Name _____ Relationship _____
Soc Sec No _____ Gender ☐ M ☐ F Birth Date _____
☐ Add this family member for life insurance only (no health coverage)
6. Name _____ Relationship _____
Soc Sec No _____ Gender ☐ M ☐ F Birth Date _____
☐ Add this family member for life insurance only (no health coverage)
7. Name _____ Relationship _____
Soc Sec No _____ Gender ☐ M ☐ F Birth Date _____
☐ Add this family member for life insurance only (no health coverage)
8. Name _____ Relationship _____
Soc Sec No _____ Gender ☐ M ☐ F Birth Date _____
☐ Add this family member for life insurance only (no health coverage)

► Authorization

I authorize the insurance carriers to coordinate benefits and process claims for my family and me. I authorize King County to deduct the cost of any self-paid coverage I've chosen from my paycheck. I understand the elections I've made are binding and cannot be revoked or modified except as explained in the materials provided and until I submit the appropriate change form.

Employee signature _____ Date signed _____

Soc Sec No _____

Affidavit of Marriage/ Domestic Partnership



► Check all boxes that apply

- ☐ Add my spouse/domestic partner (DP) for benefit coverage.
- ☐ This form documents my marriage/domestic partnership, but do not add my spouse/domestic partner for coverage at this time.
- ☐ My spouse/DP is also a King County employee.

► Check one of the following boxes and provide the date

- ☐ I (employee) certify my spouse (named below) and I legally married (date) _____.
- ☐ I (employee) certify my domestic partner (named below) and I began our domestic partnership (date) _____ and we:
 - Share the same regular and permanent residence
 - Have a close personal relationship
 - Are jointly responsible for *basic living expenses**
 - Are not married to anyone
 - Are both 18 years of age or older
 - Are not related by blood closer than would bar marriage in the State of Washington
 - Were mentally competent to consent to contract when our domestic partnership began, and
 - Are each other's sole domestic partners and are responsible for each other's common welfare.

** Basic living expenses means the cost of basic food, shelter and any other expenses of a domestic partner paid at least in part by a program or benefit for which the partner qualified because of the domestic partnership. Individuals need not contribute equally or jointly to the cost of these expenses as long as they both agree they are responsible for the cost.*

► Authorization

I understand this affidavit will no longer be effective if my spouse/domestic partner dies or if there is a change of circumstances attested to in this affidavit. I agree to notify Benefits and Retirement Operations or the appropriate payroll/personnel representative if there is any change of circumstances attested to in this affidavit within 30 days of such change by filing a Delete Family Member form. I understand the willful falsification of information on this affidavit may lead to disciplinary action up to and including discharge from employment.

We understand this information will be held confidential and subject to disclosure only upon express written authorization or if otherwise required by law. We understand this declaration of responsibility for our common welfare may have legal implications under Washington State law. We understand a civil action may be brought against us for any losses, including reasonable attorney fees, because of a false statement contained in this Affidavit of Marriage/Domestic Partnership. We certify under penalty of perjury, under the laws of the State of Washington, the foregoing is true and correct.

Employee

Employee signature _____

Date signed _____

Soc Sec No _____

Spouse/Domestic Partner

Spouse/DP signature _____

Date signed _____

Printed Name _____

Year-End New Hire Open Enrollment Form



Your enrollment forms elect your coverage through December 31 and, though you're just making those elections, you must be given the opportunity to change the coverage effective January 1. During open enrollment you may change medical plans, add enhanced life insurance for yourself (with evidence of insurability) and add eligible family members for coverage.

Please complete this form and return it with your other enrollment forms **within a week of when you begin work** to the Sheriff's Office Personnel Unit, KC Courthouse KCC SO-0100, 516 Third Ave., Seattle 98104-2312.

► **No Change** *If you check this box, check no others.*

☐ I want to keep the same coverage in 2004 that I've elected with my other forms.

► **Change Medical**

Effective January 1, 2004, make my election:

☐ Regence BlueShield ☐ PacifiCare ☐ Group Health

► **Change Enhanced Life** *If you decline enhanced at first, then add it in 2004, you must provide evidence of insurability.*

Effective January 1, 2004, make my election:

☐ Decline ☐ Accept 1 x base annual salary (minus \$6,000)

► **Add Family Members** *Provide documentation as described on page 8 of this guide.*

Effective January 1, 2004, add these eligible family members for coverage:

1. Name _____ Relationship _____
Soc Sec No _____ Gender ☐ M ☐ F Birth Date _____
☐ Add this family member for life insurance only (no health coverage)
2. Name _____ Relationship _____
Soc Sec No _____ Gender ☐ M ☐ F Birth Date _____
☐ Add this family member for life insurance only (no health coverage)
3. Name _____ Relationship _____
Soc Sec No _____ Gender ☐ M ☐ F Birth Date _____
☐ Add this family member for life insurance only (no health coverage)
4. Name _____ Relationship _____
Soc Sec No _____ Gender ☐ M ☐ F Birth Date _____
☐ Add this family member for life insurance only (no health coverage)
5. Name _____ Relationship _____
Soc Sec No _____ Gender ☐ M ☐ F Birth Date _____
☐ Add this family member for life insurance only (no health coverage)

► **Authorization**

I've read and understand this form. The information I've provided is true, correct and complete. I authorize King County to deduct the cost of any self-paid coverage I've chosen from my paycheck. I understand the elections I've made are binding and cannot be revoked or modified except as explained in the materials provided and until I submit the appropriate change form.

Employee signature _____ Date signed _____

Soc Sec No _____

